

Health Benefits Election Form

 $Federal\ Employees\ Health\ Benefits\ Program$

For Employees, Former Spouses Under the Spouse Equity Law, and Individuals

Eligible for Temporary Continuation of Coverage

Form Approved: OMB No. 3206-0160

| Name (inst. first. middle initial) 2. Social Security number 3. Due of binth mot. dut. yr.) | • Complete Parts A and G, and Parts B C, D, E, and F as applicable. Eligible for Temporary Continuation of Coverage Do not separate the copies. Your employing office will certify the completed form and return your copy to you. | | | | | | | | | | Type or print firmly Sign and date in Part G | | |
|--|---|--------------------------------------|---|--|--|-------------|---------------------|-------------------------|---|-------------------------------|--|--------|--|
| A. Your home mailing address (localide ZIF code) 2. See E. Any you now married | PART A - Fill in this part. | | | | | | | | | | | | |
| PART B - Fill in this part if you with to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program. Lelects to modif in a levelth lequifits plan as shown below. (Cupy the information requested below from front cover of bree-barre of the plan was select.) Name of plan 2a. Names of family members (fast, first, modifie infried) 2b. ZIP code 2c. Date of bitch (fast, first, modifie infried) 2c. Date of bitch (fast, first, modifie infried) 2d. Days your spouse or any other eligible family members have any goung health insurance coverage other than the FEHB plan in which you are new enrolling or enrolled? No Year Spouse TRECARE (Including CHAAPPUS) PART C - Fill in this part, as well as PART B, to change consultants code PART B - Employees Only PART F - Consellation PART F - Consellation PART F - Consellation PART F - Consellation Part | 1. Name (last, first, middle initial) | | 2. Social Security number | | | | | | 3. Date of birth (<i>mo.</i> , <i>day</i> , <i>yr</i> .) | | | | |
| PART B - Fill in this part if you with to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program. Lelects to modif in a levelth lequifits plan as shown below. (Cupy the information requested below from front cover of bree-barre of the plan was select.) Name of plan 2a. Names of family members (fast, first, modifie infried) 2b. ZIP code 2c. Date of bitch (fast, first, modifie infried) 2c. Date of bitch (fast, first, modifie infried) 2d. Days your spouse or any other eligible family members have any goung health insurance coverage other than the FEHB plan in which you are new enrolling or enrolled? No Year Spouse TRECARE (Including CHAAPPUS) PART C - Fill in this part, as well as PART B, to change consultants code PART B - Employees Only PART F - Consellation PART F - Consellation PART F - Consellation PART F - Consellation Part | 4. Your home mailing address (include ZIP code) | | | | 5. Sex | | | | 6. Are you now | married | ? | | |
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| 8. Signature of authorized agency official and telephone number (including area | | 8. S | ignature o | f authorized a | gency offici | al and tele | ephone nur | nber (includin | ig area |) | | | |

Remarks